



Minnesota Board of Pharmacy

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Disciplinary Activity

The Minnesota Board of Pharmacy took the following disciplinary actions concerning **pharmacists** between the dates of March 23, 2011 and June 15, 2011:

Bladow, Steven L., License #119838. Dr Bladow admitted that he filled 24 controlled substance prescriptions, for a single patient, even though he knew the prescriptions to be fraudulent. Consequently, at its June 15, 2011 meeting, the Board issued a stipulation and consent order that places the following limitations on Dr Bladow's license: he must be supervised by another pharmacist if he is employed in a work setting related to the practice of pharmacy; he may not have access to any controlled substances in his work setting; he may not be a pharmacist-in-charge or a preceptor; and any employment as a pharmacist must be pre-approved by the Board's executive director. The Board also placed the following conditions on his license: he must submit evidence of completion of 15 hours of continuing education focusing on professional boundaries, pharmacy and controlled substance laws, and the duties of pharmacists and prescribers in relation to controlled substances; he must submit evidence of successful completion of an assertiveness training seminar; and he must submit a report, at least five pages long, addressing what he has learned through the above-mentioned education and training. The Board also imposed a civil penalty in the amount of \$2,500.

Bullerman, Miles, License #111765. Mr Bullerman admitted that he was discharged from the Health Professional Services Program (HPSP) for noncompliance after several random toxicology screens were positive for the alcohol metabolites, ethyl glucuronide and ethyl sulfate. Consequently, the Board adopted a stipulation and consent order at its June 15, 2011 meeting suspending his license to practice pharmacy. The suspension was stayed on condition that Mr Bullerman participates in HPSP and that he refrain from consuming substances known to interfere with the toxicology screening process, such as foods, beverages, and over-the-counter medications containing poppy seeds, hempseeds, or ethyl

alcohol. He may petition for reinstatement of his license after he is successfully discharged from HPSP.

Ciminski, John E., License #113712. Mr Ciminski agreed that he suffers from some degree of a medical condition. Given that his treating therapist has indicated that Mr Ciminski has made substantial progress in treating his illness and that he is capable of practicing as a pharmacist on a part-time basis, the Board adopted a stipulation and consent order at its May 11, 2011 meeting. The order requires Mr Ciminski to be monitored by the HPSP and allows him to petition for an unrestricted license following successful discharge from that program.

Korsch, Charles D., License #112352. Mr Korsch acknowledged that, as owner and pharmacist-in-charge of Arrow-Pasek Pharmacy, he was responsible for numerous deficiencies, including failure to document certification of prescriptions; perform quality assurance checks; maintain drug allergy information on patients; perform prospective drug utilization reviews; provide a description of medications on dispensing labels; maintain and reconcile a perpetual inventory of all Schedule II controlled substances; review and sign daily controlled substance logs; and provide evidence of completing a biennial controlled substances inventory. He further admitted dispensing legend drugs without having valid prescriptions. Consequently, at its June 15, 2011 meeting, the Board issued a stipulation and consent order that suspends Mr Korsch's license. The suspension was stayed on condition that Mr Korsch not serve as a pharmacist-in-charge or a preceptor; name another pharmacist to act as pharmacist-in-charge of Arrow-Pasek Pharmacy; retake and pass the Multistate Pharmacy Jurisprudence Examination®; and comply with quarterly inspections for a minimum of 12 months. The Board also imposed a civil penalty in the amount of \$2,500.

The Board took the following disciplinary actions concerning **pharmacy technicians** between the dates of March 23, 2011 and June 15, 2011:

Muller, Jennifer L., Registration #713098. Ms Muller conceded that the Board may consider the following facts as true for the purpose of issuing a disciplinary order. Between July 2009 and

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Pharmacists Provide Feedback at APhA: 'It's About Time! What a Great Tool'

Since the March 2011 launch of the new CPE Monitor™ service, more than 10,000 pharmacists and technicians have created their National Association of Boards of Pharmacy® (NABP®) e-Profile and obtained their permanent identification number. In its effort to educate licensees, NABP answered questions about CPE Monitor during the American Pharmacists Association (APhA) Annual Meeting and Exposition on March 25-28, 2011, in Seattle, WA, in which pharmacists shared with NABP staff positive feedback about the new service. Visitors to the booth noted that they are looking forward to using the new tool to track their continuing pharmacy education (CPE).

Beginning in the latter part of 2011, the CPE Monitor service will allow pharmacists and technicians to easily track their Accreditation Council for Pharmacy Education (ACPE)-accredited CPE credits. The service will also provide a streamlined reporting and compliance verification process for participating state boards of pharmacy, a capability scheduled for availability in 2012. In the latter part of 2011, the e-Profile ID and birth date (MMDD) will be required to receive credit for any CPE activities taken from ACPE-accredited providers. Providers will ask CPE participants to provide the ID either when registering for CPE or when submitting participation data to the provider.

Pharmacists whose names have changed since the last time they interacted with NABP will need to go through the name change process before beginning their CPE Monitor registration. Name changes can be made in the licensee's NABP e-Profile by submitting a photocopy of the document granting your name change and completing the correct NABP name change form. These downloadable forms are available on the NABP Web site at www.nabp.net/programs/cpe-monitor/cpe-monitor-service in the frequently asked questions section. One form pertains to those who have had their name change granted by a United States government agency, and the other form pertains to those who have had their name change granted by a foreign government agency. In addition to the form, licensees must submit a photocopy of the documentation noting the name change, which includes marriage license or certificate, divorce decree, or court ordered name change document.

Pharmacists and technicians may access additional information about CPE Monitor in the Programs section on the NABP Web site at www.nabp.net/programs or at www.MyCPEmonitor.net. CPE Monitor is a collaborative effort between NABP, ACPE, and ACPE providers.

Protecting Yourself from Identity Theft

Being asked for your Social Security number (SSN) when applying for a loan or credit card, or even when setting up an account with a business for a service, is now commonplace. With this increased use of SSNs comes the increased risk of identity theft, and reputable businesses have been diligent in taking measures to implement security protocols to protect their customers.

Although some may believe that non-governmental organizations are prohibited from obtaining SSNs, in fact there is no law banning private organizations, such as NABP, from collecting this information. In recent years, a federal government task force recognized the importance of SSN use by private entities and preservation of such use. In addition, many states' laws specifically permit private entities to collect and use individual SSNs for purposes of application and enrollment processes, to confirm SSN accuracy, or for internal verification or administrative purposes.

For many decades, NABP has supported the boards of pharmacy in their licensure processes and the Association adheres to state and federal

laws when collecting SSNs for purposes of internal data verification and board of pharmacy licensure processes. In addition, NABP has high security protocols and utilizes required technologies and protections, including encryption technologies, to protect sensitive information.

Some pharmacists have asked about using the National Provider Identifier (NPI) number from the Centers for Medicare & Medicaid Services (CMS) as an alternative to providing their SSN. However, applying for an NPI number requires candidates to disclose their SSN to CMS, and may not address candidate concerns about providing their SSN to third parties. In addition, this excludes pharmacy technicians, who are not eligible for an NPI number.

A verification process using the SSN is the best way for organizations like NABP to help ensure the accuracy of data within its systems. NABP collects and reports data such as examination scores and continuing education records to the boards of pharmacy and having incorrect data could create serious adverse consequences for licensees. The use of the full nine-digit SSN, along with other demographic information such as license number(s), will help NABP internally verify that each profile created within its systems is unique, contains accurate information, and will match state board licensure records. The SSN is not used for any other purposes and is not shared with other entities except for the purposes of delivering requested services.

Reputable organizations use secure collection, storage, and disposal procedures, such as SSL encryption, access restriction and monitoring, firewalls, and shredding to protect customers information and thwart would-be hackers and identity thieves. Nevertheless, understanding how identity thieves steal your information will help you protect yourself from identity theft. According to the Social Security Administration thieves acquire your personal information by:

- ◆ Stealing wallets, purses, and your mail (bank and credit card statements, pre-approved credit offers, new checks, and tax information);
- ◆ Stealing personal information you provide to an unsecured site on the Internet, from business or personnel records at work, and personal information in your home;
- ◆ Rummaging through your trash, the trash of businesses, and public trash dumps for personal data;
- ◆ Posing by phone or e-mail as someone who legitimately needs information about you, such as employers or landlords; or
- ◆ Buying personal information from "inside" sources. For example, an identity thief may pay a store employee for information about you that appears on an application for goods, services, or credit.

Contaminated TPN Spurs ISMP Call for Action

In response to the infections of 19 Alabama patients by contaminated total parenteral nutrition (TPN), the Institute for Safe Medication Practices (ISMP) called upon Food and Drug Administration (FDA) to take several actions, including collaborating with boards of pharmacy in enforcing compounding standards. An investigation led by Alabama Department of Public Health and Centers for Disease Control and Prevention (CDC) determined that a failure in a step of the sterilization process for the compounded TPN most likely led to its contamination with *Serratia marcescens* bacteria. Of the 19 cases of infection that resulted in Birmingham, AL, area hospitals, nine were fatal. An investigation revealed that TPN produced by Meds IV was the common source of the infections and that a container and stirrer, and a tap water spigot at Meds IV are likely the sources of the bacteria. The product was recalled by Meds IV on March 24, 2011.

ISMP has expressed support for the provision of additional resources to boards of pharmacy so that boards can survey compounding pharma-



Compliance News to a particular state or jurisdiction should not be assumed. (Consult the law of such state or jurisdiction.)

cies to enforce compliance with United States Pharmacopeia Chapter 797 standards. ISMP also calls upon FDA to work with state boards of pharmacy to support enforcement efforts. Further, ISMP calls on FDA to provide guidance documents for industry on relevant good pharmacy compounding practices. More information about ISMP's call for action is available in an April 7, 2011 article on the ISMP Web site at www.ismp.org.

ISMP Provides Strategies to Enhance Safety Procedures in Pharmacies



This column was prepared by ISMP. ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners.

ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also an FDA MedWatch partner. Call 1-800/FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at www.ismp.org. ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

When investigating errors, look for contributing factors and then apply prevention recommendations that make sense for your organization. Use a variety of the strategies listed below to focus on system issues and human factors, to continually enhance safety procedures in your pharmacy. Share this information with colleagues at your site and within your greater organization.

Fail-safes and constraints involve true system changes in the design of products or how individuals interact within the system. For instance, when the pharmacy computer system is integrated with the cash register, a fail-safe would prevent the clerk from "ringing up" the prescription unless final verification by a pharmacist had occurred.

Forcing functions are procedures that create a "hard stop" during a process to help ensure that important information is provided before proceeding. For example, a pharmacy computer system is integrated with the cash register and requires the patient's date of birth be asked and entered at the point of sale.

Automation and computerization of medication-use processes can reduce reliance on memory. Examples include true electronic systems that can receive electronic prescriptions from a prescriber, thus eliminating data entry misinterpretation at the pharmacy and robotic dispensing devices with bar coding.

Standardization creates a uniform model to adhere to when performing various functions and to reduce the complexity and variation of a specific process. For example, create standardized processes to guide the pharmacist's final verification of a medication.

Redundancies incorporate duplicate steps or add another individual to a process, to force additional checks in the system. Involving two individuals in a process reduces the likelihood that both will make the same error with the same medication for the same patient. Examples include use of both brand and generic names when communicating medication information. Patient counseling is often an underutilized redundancy that can detect many errors.

Reminders and checklists help make important information readily available. For example, prescription blanks that include prompts for important information (eg, medication indication, allergies, patient birth date).

Rules and policies are useful and necessary in organizations. Effective rules and policies should guide staff toward an intended positive outcome. However, some may add unnecessary complexity and may be met with resistance, especially when implemented in haste in response to an error. Because their use relies on memory, they should be used as a foundation to support other strategies that target system issues.

Education and information are important tactics when combined with other strategies that strengthen the medication-use system. The effectiveness of these tactics relies on an individual's ability to remember what has been presented. Thus, on their own, they offer little leverage to prevent errors. An example of an education strategy would be having pharmacy personnel read and review policies and procedures on how to correctly perform a function such as prescription verification.

FDA Warning: Benzocaine Use and Rare, But Serious Condition

FDA has issued a warning to consumers and health care providers regarding the use of benzocaine and its association with a rare, but serious condition, methemoglobinemia. Methemoglobinemia results in the amount of oxygen carried through the bloodstream being greatly reduced, and in the most severe cases, can result in death. Benzocaine gels and liquids are sold over-the-counter under different brand names – such as Anbesol®, Hurracaine®, Orajel®, Baby Orajel, Orabase®, and store brands – and are used to relieve pain from a variety of conditions including teething, canker sores, and irritation of the mouth and gums. Benzocaine is also sold in other forms such as lozenges and spray solutions.

FDA notes that methemoglobinemia has been reported with all strengths of benzocaine gels and liquids, including concentrations as low as 7.5%. Further, the cases occurred mainly in children aged two years or younger who were treated with benzocaine gel for teething. Symptoms include pale, gray, or blue colored skin, lips, and nail beds; shortness of breath; fatigue; confusion; headache; lightheadedness; and rapid heart rate and usually appear within minutes to hours of applying benzocaine. Symptoms may occur with the first application of benzocaine or after additional use. FDA advises that if consumers or their children experience any of these symptoms after taking benzocaine, they should seek medical attention immediately. The FDA safety warning is available at www.fda.gov.

FDA Reminder About Pradaxa Storage/Handling

FDA issued a safety alert regarding special handling instructions for Pradaxa® due to concerns that these requirements are not commonly known. FDA advises that Pradaxa, an anticoagulant medication known as a direct thrombin inhibitor, should only be dispensed and stored in the original bottle or blister package due to the potential for product breakdown from moisture and loss of potency.

Specifically, FDA advises pharmacists that Pradaxa should only be dispensed in the original manufacturer bottle with the original dessiccant cap. Pradaxa should not be repackaged. Patients should be advised to store the medication in the original container and avoid using pill boxes or other containers for storage. Also, once a bottle is opened, the product must be used within 30 days to ensure potency. The Pradaxa label and medication guide contain more information about these storage and handling requirements. The FDA safety alert is available on the FDA Web site at www.fda.gov.

February 2010, several hundred tablets of generic Percocet® went missing from the pharmacy where she was employed as a technician. On at least nine occasions during this time period, Ms Muller removed 100 generic Percocet unit dose tablets from a narcotic control cabinet for the stated use of dispensing outpatient prescriptions. However, the product was returned to the control cabinet on only three of these occasions. Upon identification of these discrepancies, the pharmacy attempted a more thorough investigation of her actions by reviewing dispensing records. However, Ms Muller had already taken many of the dispensing records home. The pharmacy asked her to return the records, but she failed to do so and instead tendered her resignation. Consequently, at its May 11, 2011 meeting, the Board adopted a stipulation and consent order accepting Ms Muller's voluntary surrender of her pharmacy technician registration.

Beal, Matthew G., Registration #719009. Mr Beal agreed that he had tried to obtain prescriptions for controlled substances at several different clinics during a short period of time in May 2009. He also admitted that he had inappropriately taken controlled substances from a "return bin" at the hospital at which he worked and that he had a chemical dependency problem. Consequently, at its May 11, 2011 meeting, the Board adopted a stipulation and consent order suspending his registration as a pharmacy technician. Mr Beal may petition for reinstatement of his registration following 12 months of documented, uninterrupted sobriety.

The Board considers the following technician to have voluntarily surrendered her registration: **Gilgenbach, Patsy K., Registration #718942.**

Board Member Resignation and Appointments

On June 23, 2011, Governor Mark Dayton reappointed Karen Bergrud as a pharmacist member of the Minnesota Board of Pharmacy. Ms Bergrud, of Stewartville, MN, has over 28 years of experience in the pharmacy field. She is the assistant director of pharmacy operations at Mayo Clinic in Rochester, MN. In addition to her duties at Mayo, she is responsible for the operations of the central and satellite pharmacies at Saint Mary's and Rochester Methodist hospitals. Ms Bergrud received her bachelor of science degree in pharmacy from the University of Minnesota. She is a member of the Minnesota Society of Health-System Pharmacists. Ms Bergrud was first appointed in 2007 by Governor Tim Pawlenty.

Governor Dayton also appointed Stuart Williams as a public member of the Board. Mr Williams is a shareholder in the Minneapolis law firm of Henson & Efron, P.A., where his practice includes business litigation and environmental law. He obtained his BA and JD degrees from the University of North Carolina at Chapel Hill and served in the United States Army. Mr Williams also serves on the Board of Nursing, appointed by Governor Pawlenty in 2010, and on the Lawyers Board of Professional Responsibility, appointed by the Minnesota Supreme Court in 2007 and reappointed in 2010. He is replacing Carleton Crawford, who served two terms on the Board, having been

first appointed by Governor Pawlenty in June 2003. The Board thanks Mr Crawford for his eight years of dedicated and capable service to the citizens of Minnesota.

At the Board's June 15, 2011 meeting, Dr Stacey Jassey announced her resignation as a pharmacist member of the Board. Dr Jassey has been hired by a new employer that determined that her continued service on the Board might present a conflict of interest, given that the company is regulated by the Board of Pharmacy. She was first appointed to the Board by Governor Pawlenty in March 2008. The Board thanks Dr Jassey for her dedicated and capable service to the citizens of Minnesota and wishes her success in her new employment.

Board of Pharmacy Elects New Officers

At its meeting of June 15, 2011, the Board of Pharmacy elected pharmacist James Koppen, of Pine City, MN, to fill out the remainder of Dr Jassey's term as Board president. The Board also elected pharmacist Laura Schwartzwald, to replace Mr Koppen as vice president.

Mr Koppen served as the director of pharmacy at Pine Medical Center in Sandstone, MN, where he supervised all pharmacy operations including the upgrading of the medication delivery system and the launching of a medication safety program. He is a licensed pharmacist with over 39 years of experience in both retail and hospital pharmacy. Mr Koppen earned his bachelor of science degree in pharmacy from South Dakota State University, in Brookings, SD. He was appointed to the Board in 2009 by Governor Pawlenty.

Laura J. Schwartzwald, of Aitkin, MN, owns Arrowhead Pharmacy in Grand Marais, MN, and GuidePoint Pharmacy, with locations in Brainerd, Redwood Falls, Rochester, and Worthington, MN. Ms Schwartzwald has held staff pharmacist and pharmacy manager positions for a number of pharmacies in Minnesota and Wisconsin for 22 years. She earned her bachelor of science degree in pharmacy from North Dakota State University in Fargo, ND. She is a member of the American and Minnesota Pharmacists Associations, is a pharmacy instructor with the University of Minnesota (U of M) College of Pharmacy, serves on the U of M's Committee on Experiential Practice, mentors pharmacy students, organizes community clinics at local group homes and businesses, has developed and implemented diabetic care centers in pharmacies, and performs diabetic screenings at the Crow Wing County Fair. In 2007 and 2008 Schwartzwald received the Community Preceptor of the Year, an award given annually by the U of M College of Pharmacy to a candidate who exemplifies exceptional practice in the pharmacy profession. She was appointed to the Board in 2010 by Governor Pawlenty.